

(except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

§ 447.60 Cost-sharing requirements for services furnished by MCOs.

Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost-sharing charges imposed by the State agency.

[67 FR 41116, June 14, 2002]

ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

SOURCE: 73 FR 71851, Nov. 25, 2008, unless otherwise noted.

§ 447.62 Alternative premiums and cost sharing: Basis, purpose and scope.

(a) Section 1916A of the Act sets forth options for a State through a Medicaid State plan amendment to impose alternative premiums and cost sharing, which are premiums and cost sharing that are not subject to the limitations under section 1916 of the Act as described in §§ 447.51 through 447.56. For States that impose alternative premiums or cost sharing, §§ 447.64, 447.66, 447.68, 447.70, 447.71, 447.72, 447.74, § 447.76, 447.78, 447.80, and 447.82 prescribe State plan requirements and options for alternative premiums and cost sharing for a group or groups of individuals (as specified by the State) for services or items (as specified by the State) and the standards and conditions under which States may impose them. The State may vary the premiums and cost sharing among groups of individuals or types of services or items, consistent with the limitations specified in this subpart and section 1916A(a)(1) of the Social Security Act. Otherwise, premiums and cost sharing must comply with the requirements described in §§ 447.50 through 447.60.

(b) Waivers of the limitations described in this subpart on deductions,

cost sharing, and similar charges may be granted only in accordance with the provisions of section 1916(f) of the Act.

[75 FR 30262, May 28, 2010]

§ 447.64 Alternative premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes alternative premiums, enrollment fees, or similar fees on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the premiums, enrollment fees, or similar charges.

(b) The schedule of the premiums, enrollment fees, or similar fees imposed.

(c) The methodology used to determine family income for purposes of the limitations on premiums related to family income level that are described in § 447.78(c) of this chapter, including the period and periodicity of those determinations.

(d) The methodology used by the State to:

(1) Identify beneficiaries who are subject to premiums or cost sharing for specific items or services; and

(2) If the State adopts cost sharing rules that could place families at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid, defined at § 447.78, track beneficiaries' incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform beneficiaries and providers of beneficiaries' liability and notify beneficiaries and providers when individual beneficiaries have incurred family out-of-pocket expenses up to that limit and are no longer subject to further cost sharing for the remainder of the family's current monthly or quarterly cap period.

(e) The process for informing the beneficiaries, applicants, providers, and the public of the schedule of premiums, enrollment fees, or similar fees for a group or groups of individuals in accordance with § 447.76.

(f) The notice of, time frame for, and manner of required premium payments for a group or groups of individuals and

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the consequences for an individual who does not pay.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30262, May 28, 2010]

§ 447.66 General alternative premium protections.

(a) States may not impose alternative premiums upon the following individuals:

(1) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i) of the Act, and including individuals with respect to whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Pregnant women.

(3) Any terminally ill individual receiving hospice care, as defined in section 1905(o) of the Act.

(4) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if the individual is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(5) Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(6) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(7) An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(b) States may exempt additional classes of individuals from premiums.

(c) Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums that may

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apply to an individual receiving Medicaid who is an Indian.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30262, May 28, 2010]

§ 447.68 Alternative copayments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.

When a State imposes alternative copayments, coinsurance, deductibles, or similar cost sharing charges on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the cost sharing charge.

(b) The methodology used to determine family income, for purposes of the limitations on cost sharing related to family income level that are described in § 447.78(c) of this chapter, including the period and periodicity of those determinations.

(c) The schedule of the copayments, coinsurance, deductibles, or similar cost sharing charges imposed for each item or service for which a charge is imposed.

(d) The methodology used by the State to identify beneficiaries who are subject to premiums or cost sharing for specific items or services and, if families are at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid defined at § 447.78, track beneficiaries' incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform beneficiaries and providers of beneficiaries' liability and notify beneficiaries and providers when individual beneficiaries have incurred family out-of-pocket expenses up to that limit and are no longer subject to further cost sharing for the remainder of the family's current monthly or quarterly cap period.

(e) The process for informing beneficiaries, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals in accordance with § 447.76.

(f) The methodology used to ensure that:

(1) The aggregate amount of premiums and cost sharing imposed under